PRINTED: 08/17/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665 NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORTH VERNON		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 	(X3) DATE SURVEY COMPLETED 07/26/2022	
		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
Bldg	conducted by the In accordance with 42 Survey Date(s): 07 Facility Number: 07 Provider Number: AIM Number: 200 At this Emergency Care of North Verr compliance with E Requirements for M Participating Provides 3.73. The facility has 12 the survey, the cent Quality Review co	27/25/22 & 07/26/22 2010996 155665 20232210 Preparedness survey, Majestic non was found not in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR O certified beds. At the time of	E 0000	The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusion is forth in the statement of deficiencies, or any violation regulation. The provider respectfully requests that State Report Plan of Corrections is considerered the Letter of Credible Allegation & request desk review regarding plan of correction. The provider alleges compliance as of 7/25/22 = "" b="">	not his et of ate e
E 0024 SS=F Bldg	MET as evidenced 403.748(b)(6), 41 441.184(b)(6), 484 483.73(b)(6), 484 485.68(b)(4), 485 491.12(b)(4), 494 Policies/Procedur §403.748(b)(6), § §441.184(b)(6), § §483.73(b)(6), §4	by: 6.54(b)(5), 418.113(b)(4), 2.15(b)(6), 483.475(b)(6), .102(b)(5), 485.625(b)(6), .727(b)(4), 485.920(b)(5),			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

§485.920(b)(5), §491.12(b)(4), §494.62(b)(5).

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155665	A. BUILDING B. WING		COMPLETED 07/26/2022	
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ENRY STREET		
MAJEST	IC CARE OF NORT	TH VERNON	NORTH	H VERNON, IN 47265		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
	[(b) Policies and p must develop and preparedness policion the emergency (a) of this section, paragraph (a)(1) of communication plasection. The policible reviewed and use are [annually for minimum, the policible address the follow (6) [or (4), (5), or (of volunteers in an emergency staffing process and role of Federally designar professionals to an emergency. *[For RNHCIs at § procedures. (6) The emergency and of strategies to addrese emergency. *[For Hospice at § procedures. (4) The emergency staffing process and role of Federally designar professionals to an emergency staffing process and role of Federally designar professionals to an emergency.	implement emergency cies and procedures, based plan set forth in paragraph risk assessment at of this section, and the an at paragraph (c) of this sies and procedures must updated at least every 2 r LTC facilities]. At a cies and procedures must ring:] 7) as noted above] The use n emergency or other g strategies, including the for integration of State and ted health care ddress surge needs during ess surge needs during an 418.113(b):] Policies and he use of volunteers in an ther emergency and other g strategies, including the emergency and other g strategies, including the for integration of State and the use of hospice emergency and other g strategies, including the for integration of State and ted health care ddress surge needs during				
	failed to ensure eme and procedures incl	riew and interview, the facility ergency preparedness policies ude the use of volunteers in the remergency staffing	E 0024	The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusions.	not this	

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strategies, including the process and role for

Event ID:

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forth in the statement of

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		A. BUILDING B. WING		COMPLETED 07/26/2022	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD ENRY STREET	
MAJEST	C CARE OF NORT	H VERNON		H VERNON, IN 47265	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
	integration of State	or Federally designated health		deficiencies, or any violatio	n of
	_	o address surge needs during		regulation. The provider	444
		cordance with 42 CFR deficient practice could affect		respectfully requests that S Report Plan of Corrections	I
	all occupants.	f		considerered the Letter of	
				Credible Allegation & reque	st a
	Findings include:			desk review regarding plan	of
	Rosed on review of	"Emergency Preparedness		correction. The provider	
		ation dated 04/15/22 with the		alleges compliance as of 8/12/22	
		he Maintenance Supervisor		What corrective action(s)	s) will
		w from 9:40 a.m. to 12:50 p.m.		be accomplished for those	'
		nergency preparedness plan for		residents found to have been	
	-	nclude the use of volunteers in		affected by the deficient prac	I
		her emergency staffing		1. The policy will be revise	I
		n interview at the time of Administrator agreed the		meet the criteria and guidance	I
		dness documentation did not		forth by the life safety regulat 2. How other residents have	I
		the use of volunteers.		the potential to be affected by	-
	1 3			same deficient practice will be	•
		viewed with the Administrator		identified and what corrective	;
		e Supervisor during the exit		action(s) will be taken.1. A	I
	conference.			Residents have the potential	
	3.1-19(b)			affected by this practice.2. Maintenance Director was	The
	3.1-19(0)			educated on the policy relate	d to
				the alleged deficient practice	
				What measures will be put in	
				place and what systemic cha	•
				will be made to ensure that the	ne
				deficient practice does not	
				recur.1. The Maintenance Director/designee will provide	_
				education the Majestic Care	
				North Vernon employees 4.	-
				How the corrective action(s)	will be
				monitored to ensure the defic	cient
				practice will not recur, i.e., wh	
				quality assurance program w	
				put into place.1. For quality	<i>/</i>

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		IDENTIFICATION NUMBER 155665	A. BUILDING B. WING		COMPLETED 07/26/2022
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET I VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
				assurance, the Maintenance Director/designee will review findings yearly, with subseque corrective action and educate identified staff.2. Findings be reported at the QA meeting monthly or until substantial compliance has been determined. 5. Date of Compliance: 8-12-2022	vany uent ion for will
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency and The hospital must standby power systemergency plan so this section and in procedures plan so (i) and (ii) of this so §483.73(e), §485.6	LTC Emergency Power ion for Participation: d standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) ection.			
	The [LTC facility a implement emerge	nd the CAH] must ency and standby power the emergency plan set			
	Emergency general generator must be the location require Care Facilities Cool Interim Amendmen 12-4, TIA 12-5, and Code (NFPA 101 and Amendments TIA	located in accordance with ements found in the Health de (NFPA 99 and Tentative hts TIA 12-2, TIA 12-3, TIA d TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		A. BUILDING B. WING		COME	PLETED 6/2022	
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP C ENRY STREET I VERNON, IN 47265	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	Emergency general The [hospital, CAI-implement the eminspection, testing requirements foun Facilities Code, NI Code. 482.15(e)(3), §483 Emergency general LTC facilities] source to power enhave a plan for hopower systems opemergency, unless *[For hospitals at §483.73(g), and C The standards incurtain this section are appreference by the D Federal Register in 552(a) and 1 CFR the material from the You may inspect a Information Resource (NARA). For information Resource (NARA). For information this material at NA go to: http://www.archive.of_federal_regular fany changes in the standards in the second secon	3.73(e)(2), §485.625(e)(2) ator inspection and testing. If and LTC facility] must ergency power system It and [maintenance] It in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) In the Health Care FPA 110, and Life Safety 3.				
			i	1		i

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION G	(X3) DATE SURVEY COMPLETED 07/26/2022		
		ROVIDER OR SUPPLIEF		701	ET ADDRESS, CITY, STATE, ZIP COD HENRY STREET RTH VERNON, IN 47265	
	(X4) ID PREFIX			ID PREFIX	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
_	TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		Batterymarch Par Quincy, MA 02169 1.617.770.3000. (i) NFPA 99, Heal 2012 edition, issu- (ii) Technical inter NFPA 99, issued (iii) TIA 12-3 to NF 2012. (iv) TIA 12-4 to NF 2013. (v) TIA 12-5 to NF 2013. (vi) TIA 12-6 to NF 2014. (vii) NFPA 101, Li edition, issued Au (viii) TIA 12-1 to N 11, 2011. (ix) TIA 12-2 to NF 30, 2012. (x) TIA 12-3 to NF 22, 2013. (xii) TIA 12-4 to NF 22, 2013. (xiii) NFPA 110, S	th Care Facilities Code, ed August 11, 2011. im amendment (TIA) 12-2 to August 11, 2011. FPA 99, issued August 9, FPA 99, issued March 7, FPA 99, issued August 1, FPA 99, issued March 3, fe Safety Code, 2012			
		including TIAs to chapter 7, issued August 6, 2009 Based on record review and interview, the facility		E 0041	The creation and submission	on of 08/12/2022
		failed to implement inspection, testing a found in the Health 110, and Life Safet	the emergency power system and maintenance requirements Care Facilities Code, NFPA y Code in accordance with 42 This deficient practice could	L 0041	this Plan of Correction does constitute an admission by provider of any conclusion forth in the statement of deficiencies, or any violatio regulation. The provider respectfully requests that S Report Plan of Corrections considerered the Letter of	s not this set n of tate

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED	
		155665	B. WING		07/26/2022	
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET		
WAJEST	IC CARE OF NORT	H VEKNUN	NORTE	I VERNON, IN 47265		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG		5.112	
		of Direct Supply TELS		Credible Allegation & reques		
	_	tation "Emergency Power		desk review regarding plan o	of	
		enerator Under Load"		correction. The provider		
		the most recent twelve month		alleges compliance as of		
	_	intenance Supervisor during		8/12/22		
		9:40 a.m. to 12:50 p.m. on		What corrective action(s)	will	
		load testing documentation for		be accomplished for those		
	-	fired emergency generator for		residents found to have been		
	_	d of August 2021 through		affected by the deficient		
	· ·	ot available for review. Based		practice.1. All residents have		
		time of record review, the		the potential to be affected by		
	_	visor stated he started		alleged deficient practice. Fac	•	
	_	ity earlier in 2022 and agreed		generator has been tested "ur	ider	
	-	g documentation for the		load" and" with no load". Facil	ty	
	aforementioned six	month period was not		generator met requirements d	uring	
	available for review	7.		testing2. How other residen	ts	
				having the potential to be affe	cted	
	b. Based on review	of Direct Supply TELS		by the same deficient practice	will	
	Logbook Documen	tation "Emergency Generators:		be identified and what correcti	ve	
	Exercise Generator	(with no load)" documentation		action(s) will be taken.1. All		
	for the most recent	52 week period with the		Residents have the potential t		
		visor during record review		affected by this practice.2.	Γhe	
	from 9:40 a.m. to 1	2:50 p.m. on 07/25/22, weekly		Maintenance Director was		
		ntation for the facility's diesel		educated on the regulation of	all	
	fired emergency ge	nerator for the 31 week period		facility generator testing and		
	of 08/21/21 through	n 03/25/22 was not available for		documenting in TELs 3. Wh	at	
	review. Based on in	nterview at the time of record		measures will be put into place	e	
	review, the Mainter	nance Supervisor stated he		and what systemic changes w		
	started working at t	he facility earlier in 2022 and		be made to ensure that the		
	agreed weekly gene	erator inspection		deficient practice does not		
	documentation for t	the aforementioned 31 week		recur.1. The Maintenance		
	period was not avai	lable for review.		Director/designee will audit we	eekly	
				that all documentation and tes	- ·	
	This finding was re	viewed with the Administrator		of the facility generator is		
		ee Supervisor during the exit		completed in accordance with		
	conference.	-		state and federal regulations 4		
				How the corrective action(s) w	l l	
	3.1-19(b)			monitored to ensure the defici		
				practice will not recur, i.e., who		

quality assurance program will be

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EPARTMENT OF HEALTH AND HUN	FORM APPR		
ENTERS FOR MEDICARE & MEDIC.	AID SERVICES		OMB NO. 093
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED
	155665	B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET

MAJEST	IC CARE OF NORTH VERNON		701 HENRY STREET NORTH VERNON, IN 47265		
	T	ID			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
			put into place.1. For quality		
			assurance, the Maintenance		
			Director/designee will review any		
			findings yearly, with subsequent		
			corrective action and education for		
			identified staff.2. Findings will		
			be reported at the QA meeting		
			monthly or until substantial		
			compliance has been		
ĺ			determined. 5. Date of		
			Compliance: 8-12-2022		
K 0000					
Bldg. 01					
	A Life Safety Code Recertification and State	K 0000	The creation and submission of		
	Licensure Survey was conducted by the Indiana		this Plan of Correction does not		
	Department of Health in accordance with 42 CFR		constitute an admission by this		
	483.90(a) which resulted in Immediate Jeopardy.		provider of any conclusion set		
			forth in the statement of		
	Immediate Jeopardy cited at K211 and K222		deficiencies, or any violation of		
	S., D. 4. (-), 0.7/25/22 8, 0.7/26/22		regulation. The provider		
	Survey Date(s): 07/25/22 & 07/26/22		respectfully requests that State Report Plan of Corrections be		
	Facility Number: 010996		considerered the Letter of		
	Provider Number: 155665		Credible Allegation & request a		
	AIM Number: 200232210		desk review regarding plan of		
			correction. The provider		
	At this Life Safety Code survey, Majestic Care of		alleges compliance as of		
	North Vernon was found not in compliance with		7/25/22		
	Requirements for Participation in		="" b="">		
	Medicare/Medicaid, 42 CFR Subpart 483.90(a),				
	Life Safety from Fire and the 2012 edition of the				
	National Fire Protection Association (NFPA) 101,				
	Life Safety Code (LSC), Chapter 19, Existing				
	Health Care Occupancies and 410 IAC 16.2.				
	This one story facility was determined to be of				
	Type V (111) construction and fully sprinkled.				
	The facility has a fire alarm system with smoke				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 01 COMPLETED B. WING 07/26/2022			
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0211 SS=K Bldg. 01	corridors, and hard resident sleeping ro rooms were surveyed through A104 due to facility has a capaci 102 at the time of the All areas where residence were sprinkled and services with of Egress - Aisles, passageward discharges, exit lo in accordance with of egress is continuall obstructions to emergency, unless through 18/19.2.1, 7.1. Based on observation in 1 of deficient practice of and visitors if needid A100. This deficiency results deficiency results deficient practice of and visitors if needid A100. This deficiency results deficiency results deficient practice of and visitors if needid A100.	dents have customary access all areas providing facility (led.) Impleted on 07/28/22 General General Ays, corridors, exit cations, and accesses are in Chapter 7, and the means uously maintained free of full use in case of its modified by 18/19.2.2 1. 10.1 Ittion and interview, the facility its means of egress free from 8 means of egress. This build affect 8 residents, staffing to exit the facility by Room alted in an Immediate its did in an Immediate its did in the facility by Room is to open with fire alarm 3:05 p.m. The Immediate	K 0211	The creation and submission this Plan of Correction does constitute an admission by t provider of any conclusion s forth in the statement of deficiencies, or any violation regulation. The provider respectfully requests that St Report Plan of Corrections be considerered the Letter of Credible Allegation & request desk review regarding plan of correction. The provider alleges compliance as of 8/12/22	not his set of ate se

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		ì í	ILDING	nstruction 01	(X3) DATE : COMPL 07/26/	ETED	
	PROVIDER OR SUPPLIE		•	701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
	installed a new repl door to the outside but did not complet leaving the new key of an actual fire, the release the door to being operable and with fire alarm system. The Immediate Jeo at 2:00 p.m. when the	pardy was removed on 07/26/22 he surveyor conducted a revisit			 What corrective action(s) be accomplished for those residents found to have been affected by the deficient praction. All residents have the potential to be affected by the alleged deficient practice. How other residents have the potential to be affected by 	ce. ing the	
	contractor complete necessary repairs for upon fire alarm systevening of 07/25/2. "Work Performed" from the fire alarm	on that the fire alarm system ed keypad installation and all or the door to release to open tem activation during the 2. The surveyor reviewed documentation dated 07/25/22 system inspection contractor typad was installed on 07/25/22			same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this alleged deficient practice.		
	and the mag lock for tested the fire alarm would release to op- activation. Surveyor	or the exit door was rewired and a system to ensure the door the with fire alarm system or observed on 07/26/22 the ease the door to open.			 A campus wide review w completed to ensure no other obstructions were in the way of means of egress A campus wide review w completed of all exit doors 	of a	
	Supervisor during t facility from 9:25 a exit door to the out A100 was marked and was also marked with the necessary be released to open Based on observati Supervisor during a p.m. to 3:05 p.m., t	ons with the Maintenance he initial walk through of the .m. to 9:40 a.m. on 07/25/22, the side of the facility by Room as a facility exit with an exit sign ad as a delayed egress door signage stating the door could after pushing for 15 seconds. ons with the Maintenance a tour of the facility from 12:50 he delayed egress door to the ty by Room A100 failed to			 The Maintenance Director was educated on the regulation keeping hallways and egresse free of obstructions & on mean egress regulations What measures will be printo place and what systemic changes will be made to ensure that the deficient practice does recur. 	n of s ns of ut	

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPI	LETED
		155665	B. WI	NG		07/26	
			<u> </u>				
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD ENRY STREET		
MA IEST	IC CARE OF NORT	TH VEDNION			INKY STREET I VERNON, IN 47265		
IVIAJEST		TITVERNON		NORTI	T VERNON, IN 47205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG			DATE
	_	r pushing on the door for 15			The facility Maintenance		
	_	mes. The door also had a			Director/designee will complet		
	. –	loor to release the door to open			100% audit 5 times a week for	3	
	but the code to rele	ase the door to open was not			months during his rounding of	the	
	posted at the exit do	oor. In addition, the front			East and West buildings to en	sure	
	_	keypad was partially			hallways and common areas a	ire	
		the portion of the keypad			free of obstructions.		
	affixed to the wall a	and the keypad appeared to					
	have no electrical p	ower. The keypad was			2. The facility Maintenance		
		aintenance Supervisor stated			Director/designee will complete	e a	
	_	ction contractor installed a new			100% audit 5 times a week		
	keypad on Saturday	(07/23/22) and was scheduled			ongoing of facility fire egress of	loors	
	to complete repairs	for the keypad installation this					
	coming Wednesday	(07/27/22). The Maintenance			4. How the corrective action	(s)	
	Supervisor stated th	ne door is also supposed to			will be monitored to ensure the	9	
	release to open with	n fire alarm system activation.			deficient practice will not recur	,	
	Based on observation	ons at 3:05 p.m. on 07/25/22,			i.e., what quality assurance		
	the Maintenance Su	pervisor activated the fire			program will be put into place.		
	alarm system at 3:0	5 p.m. by activating a manual					
	pull station by the e	exit door by Room A100. The			1. For quality assurance, th	ie	
	exit door failed to r	elease to open with fire alarm			Maintenance Director/designe	е	
	system activation.	Based on interview at the time			will review any findings daily, v	vith	
	of the observations.	, the Maintenance Supervisor			subsequent corrective action a	and	
	stated the exit door	should have released to open			education for identified staff.		
	with fire alarm syst	em activation and contacted					
	the fire alarm system	m contractor who stated they			2. Findings will be reported	at	
	were in route for th	e repairs.			the QA meeting monthly or un	til	
					substantial compliance has be	en	
		viewed with the Administrator			determined.		
	and the Maintenance	ee Supervisor during the exit					
	conference.				5. Date of Compliance:		
					8-12-2022		
	3.1-19(b)						
	2 Rased on observe	ation and interview, the facility					
		he means of egress free from					
		8 means of egress. This					
		ould affect over 20 residents,					
	1 actional practice of	oura arreer over 20 residents,	1		i		I

staff and visitors.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		l í	UILDING	nstruction 01	(X3) DATE COMPL 07/26	ETED		
	PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET					
MAJESI	IC CARE OF NORT	n vernon		NORTH	VERNON, IN 47265			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	(X5) COMPLETION DATE	
	Findings include:							
	Supervisor during t facility from 9:25 a large, padded whee corridor outside Ro half of the eight-foo one large stainless with cardboard box concentrators were the kitchen near the oxygen storage and observations with the during a tour of the p.m., the large, pad in the corridor outsistored in the corridor and transfilling root corridor. Based on observations, the M the aforementioned continuously maint to full use in case of	ons with the Maintenance he initial walk through of the i.m. to 9:40 a.m. on 07/25/22, a lchair was stored in the om D101 and blocked nearly of-wide corridor. In addition, steel meal serving cart, a cart ies and seven oxygen stored in the corridor outside exit door of the facility by the transfilling room. Based on he Maintenance Supervisor facility from 12:50 p.m. to 3:05 ded wheelchair was still stored ide Room D101, and all items or outside the oxygen storage m were still stored in the interview at the time of the faintenance Supervisor agreed means of egress were not ained free of all obstructions of emergency. Eviewed with the Administrator we Supervisor during the exit						
K 0222	NFPA 101							
SS=K	Egress Doors							
Bldg. 01	Egress Doors							
		ed means of egress shall not						
		a latch or a lock that of a tool or key from the						
		s using one of the following						
	special locking an	9						
	CLINICAL NEEDS OR SECURITY THREAT							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		, ,	UILDING	nstruction 01	(X3) DATE COMPL 07/26	ETED		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265					
1717 10 20 1	10 07 11 2 07 11 01 11			1	72.4.43.4, 117.7.233			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	LOCKING							
	-	king arrangements for the						
		eeds of the patient are						
	1	cking device shall be						
	1 '	n door and provisions shall						
		apid removal of occupants						
	1 -	l of locks; keying of all						
	_	ied by staff at all times; or						
	other such reliable means available to the							
	staff at all times.							
	18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1,							
	19.2.2.2.6							
	SPECIAL NEEDS LOCKING							
	ARRANGEMENTS							
	-	cking arrangements for the						
	1	ne patient are used, all of						
		curity Locking requirements						
	_	addition, the locks must be						
		at fail safely so as to						
	· ·	of power to the device; the ed by a supervised						
		er system and the locked						
		d by a complete smoke						
	I .	(or is constantly monitored						
	•	cation within the locked						
		the sprinkler and detection						
	1 ' '	nged to unlock the doors						
	upon activation.	iged to difficult the doors						
	· •	.2.2.5.2, TIA 12-4						
	DELAYED-EGRE							
	ARRANGEMENT							
		delayed-egress locking						
		in accordance with						
	1 -	permitted on door						
		ng low and ordinary hazard						
		ngs protected throughout by						
		ervised automatic fire						
		or an approved, supervised						
	automatic sprinkle							
	18.2.2.2.4, 19.2.2	-						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			X3) DATE SURVEY COMPLETED 07/26/2022		
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	(X5) COMPLETION DATE	
	ACCESS-CONTR LOCKING ARRAN Access-Controlled installed in accord be permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOBI LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblied throughout by an automatic fire dete approved, supervisystem. 18.2.2.2.4, 19.2.2 1. Based on observative failed to ensure 1 of the facility in a requarranged to unlock system activation. affect 8 residents, sexit the facility by 1. This deficiency results are the facility by 1.	COLLED EGRESS NGEMENTS I Egress Door assemblies lance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS NGEMENTS It access door locking in 7.2.1.6.3 shall be permitted les in buildings protected lapproved, supervised lection system and an lest seed automatic sprinkler 2.4 lation and interview, the facility of 6 exit doors to the outside of lired means of egress were lithe door upon fire alarm This deficient practice could laff and visitors if needing to Room A100. In the dialet defined in an Immediate lited in an Immediate lited in an interview was identified lited in an interview by Room let open with fire alarm let 3:05 p.m. The Immediate	K 02		The creation and submission this Plan of Correction does constitute an admission by provider of any conclusion of deficiencies, or any violation regulation. The provider respectfully requests that St Report Plan of Corrections to considerered the Letter of Credible Allegation & requested the Letter of Credible Allegation & requested the correction. The provider alleges compliance as of 8/12/22 1. What corrective action(s be accomplished for those residents found to have been affected by the deficient practice.	not this set n of tate pe st a of	08/12/2022	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/26/2022		
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION with fire alarm system activation.		TAG	All residents and visitors		
	The Immediate Jeopardy was removed on 07/26/22			have the potential to be affect 2. The egress door near ro	om	
	_	he surveyor conducted a revisit on that the fire alarm system		A100 that resulted in immedia jeopardy was corrected	ate	
	_	ed keypad installation and all or the door to release to open		immediately 3. The signage the exit door in the main lobb		
	upon fire alarm syst	tem activation during the		entrance was removed, becar	use	
	"Work Performed"	2. The surveyor reviewed documentation dated 07/25/22		the door is not a delayed egree 2. How other residents hav	ing	
		system inspection contractor ypad was installed on 07/25/22		the potential to be affected by same deficient practice will be		
		or the exit door was rewired and a system to ensure the door		identified and what corrective		
	would release to op	en with fire alarm system		action(s) will be taken.1. All Residents have the potential	to be	
	· ·	or observed on 07/26/22 the ease the door to open.		affected by this practice.2. A campus wide audit was done on		
	Findings include:			all egress doors to ensure functionality3. Maintenance Director was educated on the	;	
	Maintenance Super	on at 3:05 p.m. on 07/25/22, the visor activated the fire alarm		regulation of means of egress delayed egress doorways 3.	s and	
	station by the exit d	by activating a manual pull oor by Room A100. The exit se to open with fire alarm		What measures will be put int place and what systemic char will be made to ensure that the	nges	
	system activation.	Based on interview at the time the Maintenance Supervisor		deficient practice does not recur.1. The facility		
		should have released to open em activation and contacted		Maintenance Director/designed will complete a 100% audit 5	ee	
	the fire alarm system were en route for th	n contractor who stated they e repairs.		times a week for 3 months on egress doors to ensure		
	This finding was re	viewed with the Administrator		functionality and that facility is compliance with state & feder		
	and the Maintenanc conference.	e Supervisor during the exit		regulations 4. How the corrective action(s) will be		
				monitored to ensure the defic		
	3.1-19(b)			practice will not recur, i.e., when quality assurance program with the pro	ll be	
		ntion and interview, the facility means of egress through 1 of		put into place.1. For quality assurance, the Maintenance		

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	PROVIDER OR SUPPLIER		701 H	STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET					
MAJEST	IC CARE OF NORT	'H VERNON	NORT	H VERNON, IN 47265					
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)				
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)					
TAG		LSC IDENTIFYING INFORMATION cks were readily accessible for	TAG	Director/designee will review	DATE				
		nd visitors. LSC 7.2.1.6.1,		findings daily, with subseque					
		cks allows approved, listed,		corrective action and educati					
		s shall be permitted to be		identified staff.2. Findings					
		erving low and ordinary		be reported at the QA meetin	g				
	hazard contents in b			monthly or until substantial					
		oproved, supervised automatic		compliance has been					
		m installed in accordance with pproved, supervised automatic		determined.5. Date of					
	· ·	stalled in accordance with		Compliance: 8-12-2022					
		here permitted in Chapters 12							
	through 42, provide								
	(a) The doors unlock upon actuation of an								
	approved, supervised automatic sprinkler system								
		nce with Section 9.7, or upon							
	-	heat detector or not more							
		ectors of an approved,							
	_	ic fire detection system nce with Section 9.6.							
		k upon loss of power							
	* *	or locking mechanism.							
	-	process shall release the lock							
		ipon application of a force to							
		equired in 7.2.1.5.4 that shall							
	-	xceed 15 lbf nor required to be							
		d for more than 3 seconds.							
		release process shall activate							
	_	the vicinity of the door. Once							
		een released by the application sing device, relocking shall be							
	by manual means of	-							
		approved by the authority							
	•	a delay not exceeding 30							
	seconds shall be per	· -							
		acent to the release device,							
		lily visible, durable sign in							
		1 inch high and at least 1/8							
		on a contrasting background							
	that reads:	A DAM GOLDADO							
	"PUSH UNTIL AL	ARM SOUNDS.		1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/26/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORREC			(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	This deficient pract	PENED IN 15 SECONDS". ice could affect over 20 visitors if needing to exit the ain entrance lobby.					
	Findings include:						
	Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22, the exit door in the main entrance lobby was marked as a facility exit with an exit sign. The door was magnetically locked and could be released by entering a four digit code which was posted at the exit door set to release the doors to open. The exit door set was also equipped with delayed egress signage stating the doors would release to open after 15 seconds but the doors failed to release to open after pushing for more than 15 seconds multiple times. Based on interview at the time of the observations, the Maintenance Supervisor stated he was not certain the door was still arranged as delayed egress door but agreed the door was equipped with delayed egress signage and would not release to open after pushing for 15 seconds						
	_	viewed with the Administrator ce Supervisor during the exit					
K 0321 SS=E Bldg. 01	barrier having 1-h (with 3/4 hour fire						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED			ETED	
		155665	B. W	NG		07/26/	2022
		.		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	₹					
ΜΔ ΙΕςΤ	IC CARE OF NORT	TH VERNON	701 HENRY STREET NORTH VERNON, IN 47265				
WINDESTIG OF INC. THE VERTICAL		THE VERNOR		NOINII			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	accordance with 8	3.7.1 or 19.3.5.9. When the					
	approved automa	tic fire extinguishing system					
	-	e areas shall be separated					
	-	s by smoke resisting					
	-	ors in accordance with 8.4.					
	Doors shall be se	-					
	_	and permitted to have					
	nonrated or field-applied protective plates that						
	do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of						
	hazardous areas that are deficient in						
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	b. Laundries (larg c. Repair, Mainter d. Soiled Linen Rogallons) e. Trash Collectio (exceeding 64 gal f. Combustible Sto (over 50 square for Laboratories (if Hazard - see K32 Based on observatifailed to ensure 2 o	r-Fired Heater Rooms er than 100 square feet) nance, and Paint Shops coms (exceeding 64 n Rooms flons) prage Rooms/Spaces eet) classified as Severe	K 0	321	The creation and submission this Plan of Correction does constitute an admission by t	not	08/12/2022
	other spaces by smodoors. Doors shall closing in accordan practice could affect visitors. Findings include:	be self-closing or automatic ce with 7.2.1.8. This deficient ct over 20 residents, staff and			provider of any conclusion second forth in the statement of deficiencies, or any violation regulation. The provider respectfully requests that Statement of Considerered the Letter of Credible Allegation & request desk review regarding plants.	et of ate e	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/26/2022		
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORT		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
PREFIX (EACH DEFICIEN TAG REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
p.m. to 3:30 p.m. or foot square hole wa water softener room the attic above. Fiv penetrated the open	tour of the facility from 12:50 a 07/25/22, a one- and one-half is noted in the ceiling of the a by the kitchen which exposed e pipes and conduits ing. Two layers of 5/8ths inchoted for the ceiling in the room.		correction. The provider alleges compliance as of 8/12/22			
In addition, a one-form the ceiling of the spabove the two-wall the room. Two lays was also noted for crooms contained nate Based on interview observations, the Mathematical the cause of the hole but agreed the open aforementioned room hazardous areas from resistant partitions at This finding was re-	pot square hole was noted in rinkler riser room directly mounted electrical panels in ers of 5/8ths inch thick drywall eiling of the riser room. Both tural gas fuel-fired equipment, at the time of the aintenance Supervisor stated was replaced last week which e in the ceiling for that room ings in the ceiling of the ms did not separate these m other spaces with smoke		What corrective action(s) will accomplished for those reside found to have been affected be deficient practice. The one- and one-half foot so hole in the ceiling of the water softener room by the kitchen exposing the attic was repaired the maintenance director. In addition, the one-foot square was noted in the ceiling of the sprinkler riser room above the electric panel was repaired by maintenance director. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. The deficient practice could a over 20 residents, staff, and visitors A campus wide audit completed to ensure all hazar areas had correct fire barriers place Maintenance Director we ducated on the regulation of ensuring all necessary barrier established between hazardo areas What measures will be put int place and what systemic char will be made to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure that the deficient practice does not recompleted to ensure t	ents by the ore ore d by hole the de ffect was dous in das s are us onges e		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY COMPLETED		
		155665	B. WI	NG		07/26	/2022
	PROVIDER OR SUPPLIE			701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION
K 0324 SS=D Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipme accordance with Ventilation Contro Commercial Cook appliances such a toasters) are use cooking in accord 19.3.2.5.2 * cooking facilities smoke compartm patients comply v 18.3.2.5.3, 19.3.2	ent is protected in NFPA 96, Standard for ol and Fire Protection of king Operations, unless: ing equipment (i.e., small as microwaves, hot plates, d for food warming or limited lance with 18.3.2.5.2, s open to the corridor in ents with 30 or fewer with the conditions under		TAG	Maintenance Director/designation will complete a 100% audit 5 times a week for 3 months durounding to ensure all proper barriers are within accordance state and federal regulation reto hazardous areas. How the corrective action(s) amonitored to ensure the deficient practice will not recur, i.e., where quality assurance program with put into place. For quality assurance, the Maintenance Director/designation will review any findings daily, subsequent corrective action education for identified staff. Findings will be reported at the meeting monthly or until substantial compliance has be determined. Date of Compliance: 8-12-20	e with elated will be ient nat ill be ee with and he QA	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/26/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	conditions under 1 Cooking facilities NFPA 96 per 9.2.3 enclosed as hazar be open to the cor 18.3.2.5.1 through through 19.3.2.5.5 Based on record rev failed to ensure 1 of systems was inspec 2011 Edition, Stand Fire Protection of C	18.3.2.5.4, 19.3.2.5.1	K 0324	The creation and submissio this Plan of Correction does constitute an admission by provider of any conclusion so forth in the statement of	not this		
	the fire-extinguishin hoods containing a water system that is the grease removal plenums, and the exproperly trained, quacceptable to the au lease every six mon could affect over th kitchen.	ng systems and listed exhaust constant or fire-activated listed to extinguish a fire in devices, hood exhaust thaust ducts shall be made by alified, and certified person(s) thority having jurisdiction at ths. This deficient practice ree staff and visitors in the		deficiencies, or any violation regulation. The provider respectfully requests that S Report Plan of Corrections I considerered the Letter of Credible Allegation & requestesk review regarding plan correction. The provider alleges compliance as of 8/12/22	tate oe st a		
	system inspection of documentation date the Maintenance Su from 9:40 a.m. to 12 documentation of so system inspection s not available for rev suppression system provided "Kitchen S Inspection document could not be determined to the system of the system o	the kitchen fire suppression ontractor's inspection d 05/20/21 and 05/12/22 with pervisor during record review 2:50 p.m. on 07/25/22, emiannual fire suppression ix months after 05/20/21 was view. The kitchen fire inspection contractor also Suppression System nation dated 11/04/22 but it timed during the survey if the peen dated 11/04/21. Based		1.What corrective action(s) be accomplished for those residents found to have been affected by the deficient praction. 1.All residents have the potential to be affected by the alleged deficient practice. The facility dietary employees were re-educated on how to exting Grease Fires in the kitchen. The kitchen fire suppression system was inspected and passed inspection	tice. e e re uish		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/26/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE		
TAG	on interview at the of Maintenance Super working at the facil know if the 11/04/2 have been dated 11/04 documentation of so system inspection so not available for review. This finding was re-	time of record review, the visor stated he started ity earlier in 2022, he did not 2 inspection report should /04/21 and agreed emiannual fire suppression ix months after 05/20/21 was	TAG	How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. 1.All Residents have the potential to be affected by this practice. 2.The facility dietary employees were re-educated how to extinguish Grease First the kitchen. Also, the kitchen suppression system was inspected and passed inspected and search inspected and passed inspected and search inspected and regulation determined by the properties and also ensuring that the range hood extinguishing system and also ensure that the deficient practice does not reach the properties of the practice does not reach the	on es in fire tion was cated e e tem ne o nges e cur. tte a r 3 f the fire er nnce vill be ient at		

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ENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED		
		155665	B. W	NG		07/26	/2022	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECT		(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					1.For quality assurance, Maintenance Director/designe will review any findings daily, subsequent corrective action education for identified staff. 2.Findings will be reporte the QA meeting monthly or ur substantial compliance has be determined. Date of Compliance: 8-12-20	ee with and ed at ntil een		
K 0345 SS=F Bldg. 01	in accordance with complying with the National Electric Control National Fire Alar Records of system and testing are respected in testing are respected in the National Fire Alar Records of system and testing are respected in testing are respected in the National N	m - Testing and m is tested and maintained h an approved program e requirements of NFPA 70, Code, and NFPA 72, m and Signaling Code. m acceptance, maintenance	K 0	345	The creation and submission this Plan of Correction does constitute an admission by provider of any conclusions forth in the statement of deficiencies, or any violation regulation. The provider respectfully requests that Strength Report Plan of Corrections Requested the Letter of Credible Allegation & requested Report Plan of Corrections Repor	not this set n of tate be	08/12/2022	

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Based on review of the fire alarm system

inspection contractor's "Fire Alarm System

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8/12/22

alleges compliance as of

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	ETED
		155665	B. W	'ING		07/26/	2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1					
NAA JEGT		CLLVEDNION.		1	NRY STREET		
MAJEST	IC CARE OF NORT	H VERNON		NORTH	I VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Inspection" docume	entation dated 05/10/22 with			What corrective action(s) will be	ре	
	the Maintenance Su	pervisor during record review			accomplished for those reside	nts	
	from 9:40 a.m. to 12	2:50 p.m. on 07/25/22, the main			found to have been affected b	y the	
	fire alarm system control panel batteries need				deficient practice.		
	replacement. The "	Battery Results" section of the			All residents have the potentia	ıl to	
	05/10/22 inspection report stated "Fail" for both				be affected by the alleged defi		
	main fire alarm con	trol panel batteries. Battery			practice.		
	replacement docum	entation on or after 05/10/22			How other residents having th	е	
	was not available fo	or review. Based on interview			potential to be affected by the		
		servations, the Maintenance			same deficient practice will be		
	Supervisor stated he	e was unaware the batteries			identified and what corrective		
	failed inspection an	d testing on 05/10/22 because			action(s) will be taken.		
	page 1 of 9 of the 0.	5/10/22 report stated "All			All Residents have the potenti	al to	
	tested devices work	ed properly" but agreed			be affected by this practice. The	ne	
	battery replacement	documentation on or after			fire alarm testing system was		
	05/10/22 was not av	vailable for review. Based on			tested and met requirements s	set	
	observations with the	ne Maintenance Supervisor			forth by state and federal		
	during a tour of the	facility from 12:50 p.m. to 3:30			regulations		
	-	ne main fire alarm control panel			What measures will be put into)	
		nurse's station at the entrance			place and what systemic chan	-	
		batteries in the panel had a date			will be made to ensure that the	Э	
	-	h battery but it could not be			deficient practice does not rec		
		ate code for the batteries			Maintenance Director/designe	е	
	indicated they were	replaced on or after 05/10/22.			will complete a 100% audit 5		
					times a week for 3 months dur	ring	
	_	viewed with the Administrator			his rounding of the campus to		
		e Supervisor during the exit			ensure functionality and opera	-	
	conference.				of the fire alarm testing systen		
					How the corrective action(s) w		
	3.1-19(b)				monitored to ensure the defici-		
					practice will not recur, i.e., who		
					quality assurance program wil	l be	
					put into place.		
					For quality assurance, the		
					Administrator/designee will rev	view	
					any findings yearly, with		
					subsequent corrective action a	and	
					education for identified staff.		
					Findings will be reported at the	e QA	
					meeting monthly or until		

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STATEME	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	X3) DATE SURVEY COMPLETED 07/26/2022
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extin Portable Fire Extin Portable fire extin installed, inspecte accordance with N Portable Fire Extin 18.3.5.12, 19.3.5. Based on observatin failed to ensure 1 of were installed in accordance with N Portable Fire Extin 18.3.5.12, 19.3.5. Based on observatin failed to ensure 1 of were installed in accordance with N Portable Fire Extin 18.3.5.12, 19.3.5. Based on observatin face outward. This 10 residents, staff a Room D106. Findings include: Based on observatin Supervisor during a p.m. to 3:30 p.m. of extinguisher located in the corridor by R the cabinet such that	nguishers nguishers guishers are selected, ed, and maintained in NFPA 10, Standard for nguishers.		The creation and submission this Plan of Correction does respectfully requests that Sta Report Plan of Corrections be considered the Letter of Credible Allegation & request desk review regarding plan of correction. The provider alleges compliance as of 8/12/22 1. What corrective action(s) be accomplished for those residents found to have been affected by the deficient practice.	of 08/12/2022 not his pet of te se a f
	on interview at the Maintenance Super extinguisher was no with the operating i	ack wall of the cabinet. Based time of observation, the visor agreed the fire of positioned in the cabinet instructions and pressure guisher facing outward.		 This deficient practice ha the potential to affect 10 reside staff, and visitors. A campus wide audit was completed to ensure all facility 	nts,

This finding was reviewed with the Administrator

extinguishers were positioned in

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	OF CORRECTION	IDENTIFICATION NUMBER 155665	A. BUILDING B. WING	01	COMPLETED 07/26/2022
	ROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG		e Supervisor during the exit	TAG	the cabinet such that the operating instructions and the pressure gauge for the extinguisher were positioned correctly facing forward. 2. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. A campus wide audit was completed to ensure that all facility fire extinguishers were correctly positioned in cabinet in accordance with state and federal regulations 3. The Maintenance Direct was educated on the regulation ensuring all fire extinguishers positioned correctly in cabinet throughout the campus 3. What measures will be pinto place and what systemic changes will be made to ensur that the deficient practice doe recur. 1. The Maintenance Director/designee will comple 100% audit monthly for 3 mor during daily rounding to ensure the position of the process of	ving the east as
				proper placement of fire	I

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	X3) DATE SURVEY COMPLETED 07/26/2022	
	PROVIDER OR SUPPLIEF		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				extinguishers 4. How the corrective action will be monitored to ensure the deficient practice will not recursive, what quality assurance program will be put into place. 1. For quality assurance, the Maintenance Director/designe will review any findings daily, we subsequent corrective action and education for identified staff. 2. Findings will be reported the QA meeting monthly or unsubstantial compliance has be determined. 5. Date of Compliance: 8-12-2022	e r, ne ee with and l at
K 0363 SS=E Bldg. 01	than required enci- exits, or hazardou of smoke and are solid-bonded core capable of resistir minutes. Doors in compartments are passage of smoke to rooms containir	corridor openings in other losures of vertical openings, is areas resist the passage made of 1 3/4 inch wood or other material in its fire for at least 20 fully sprinklered smoke enonly required to resist the encorridor doors and doors in its flammable or trails have positive latching			

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hardware. Roller latches are prohibited by CMS regulation. These requirements do not

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CENTERS FOR MEDICARE & MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/26/2022		
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	flammable or com Clearance betwee covering is not exi doors complying v if provided with a ce the door closed w applied. There is closing of the doo release when the permitted. Nonrate unlimited height a meeting 19.3.6.3.6 frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restri resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratin devices, etc. Based on observatio failed to ensure 1 or impediment to close frame and would re This deficient pract staff and visitors in storage and transfill Findings include: Based on observation	che bottom of door and floor ceeding 1 inch. Powered with 7.2.1.9 are permissible device capable of keeping then a force of 5 lbf is no impediment to the rs. Hold open devices that door is pushed or pulled are red protective plates of re permitted. Dutch doors of are permitted. Door beled and made of steel or compliance with 8.3,	K 0363	The creation and submission this Plan of Correction does constitute an admission by provider of any conclusion forth in the statement of deficiencies, or any violation regulation. The provider respectfully requests that S Report Plan of Corrections considerered the Letter of Credible Allegation & reque desk review regarding plan	on of 08/12/2022 snot this set on of state be set a	

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p.m. to 3:30 p.m. on 07/25/22, the latching

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correction. The provider

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/26/2022
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	oxygen storage and kitchen failed to lat when tested to closs interview at the tim Maintenance Super to the oxygen storato latch into the document.	corridor entry door to the transfilling room near the ch the door into the door frame e multiple times. Based on e of the observations, the visor agreed the corridor door ge and transfilling room failed or frame. viewed with the Administrator e Supervisor during the exit		alleges compliance as of 8/12/22 1. What corrective action(s be accomplished for those residents found to have been affected by the deficient praction. 1. The doors of concern double the survey have been readjust and latch positively into their respective door frames. 2. How other residents had the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by the alleged deficient practice. 2. A campus wide audit was completed to ensure all facility doors latch positively into the respective door frames. 3. The Maintenance Direct was educated on the regulation having all facility doors latch positively into their respective frames. 3. What measures will be into place and what systemic changes will be made to ensure that the deficient practice does recur.	ving ving vithe e as y ir tor on of e door put

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	T OF HEALTH AND HU						RM APPROVED
	R MEDICARE & MEDIC NT OF DEFICIENCIES		(V2) M	III TIDI E CO	ONSTRUCTION	(X3) DATE	B NO. 0938-039
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO JILDING	01	COMPL	
ANDILAN	OF CORRECTION	155665			01	07/26/	
		133003	B. WING			077207	2022
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
					NRY STREET		
MAJEST	IC CARE OF NOR	TH VERNON		NORTH	H VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
					1. Maintenance		
					Director/designee will complet	e a	
					100% audit 2 times a week for	. 3	
					months during his rounding of	the	
					East and West buildings to en	sure	
					that all facility doors latch		
					positively into their respective	door	
					frames.		
					4. How the corrective action		
					will be monitored to ensure the		
					deficient practice will not recur	,	
					i.e., what quality assurance program will be put into place.		
					program will be put into place.		
					For quality assurance, th	ie.	
					Maintenance Director/designe		
					will review any findings daily, v		
					subsequent corrective action a		
					education for identified staff.		
					2. Findings will be reported	at	
					the QA meeting monthly or un	til	
					substantial compliance has be	en	
					determined.		
					5. Date of Compliance:		
					8-12-2022		
K 0372	NFPA 101						
SS=E		ilding Spaces - Smoke					
Blda. 01	Barrie	numy opaces - onloke					

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Barrier Construction 2012 EXISTING

Subdivision of Building Spaces - Smoke

Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
		155665	B. W	ING		07/26/	2022	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
MAJEST	IC CARE OF NORT	TH VERNON			:NRY STREET I VERNON, IN 47265			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
		e dampers are not required						
		ns in fully ducted HVAC						
		approved sprinkler system						
	is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)							
		hanical smoke control						
	system in REMAR	RKS.						
	1. Based on record review, observation and		K 0	372	The creation and submission of		08/12/2022	
	· ·	ty failed to ensure 1 of 6 smoke			this Plan of Correction does	not		
	barrier walls were p	protected to maintain the fire			constitute an admission by t	his		
		oke barrier. LSC Section			provider of any conclusion s	et		
	_	noke barriers to be constructed			forth in the statement of			
		LSC Section 8.5 and shall have			deficiencies, or any violation	n of		
		fire resistive rating. This			regulation. The provider			
	_	ould affect over 50 residents,			respectfully requests that St			
		the vicinity of the corridor			Report Plan of Corrections b	е		
	door set by Room C	C101.			considerered the Letter of			
					Credible Allegation & reques			
	Findings include:				desk review regarding plan	of		
	D1	C1114-1-1			correction. The provider			
	Based on review of				alleges compliance as of			
		the Maintenance Supervisor w from 9:40 a.m. to 12:50 p.m.			8/12/22			
		w from 9:40 a.m. to 12:50 p.m. fire resistance rated smoke			1 What corrective action(-)	\ varill		
		nstructed near Room B113,			What corrective action(s) be accomplished for those) WIII		
		ased on observations with the			residents found to have been			
		visor during a tour of the			affected by the deficient pract	ice		
	_	p.m. to 3:30 p.m. on 07/25/22, a			ansolida by the denoient pract	.55.		
		ter hole for the passage of			All residents have the			
		es was noted in the attic smoke			potential to be affected by the			
		he corridor door set by Room			alleged deficient practice. All			
		irestopped. Fire resistance			facility smoke barriers were			
		to the hinge side of each			audited to ensure compliance	with		
		door set by Room C101			state and federal regulations v			
		vas 90-minute fire resistance			met			
	rated and each door	self-closed and latched into						
	the door frame whe	n tested to close. Based on			2. How other residents have	/ing		
	interview at the tim	e of the observations, the			the potential to be affected by	the		
	Maintenance Super	visor agreed the			same deficient practice will be			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	
		155665	B. W	'ING		07/26/	2022
NAME OF T	DROWNED OF CURPUSE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER			701 HE	NRY STREET		
MAJEST	IC CARE OF NORT	TH VERNON		NORTH	l VERNON, IN 47265		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		ening in the attic smoke barrier ted to maintain the fire			identified and what corrective		
	resistance of the sm				action(s) will be taken.		
	resistance of the sin	loke barrier.			All Residents have the		
	This finding was re	viewed with the Administrator			potential to be affected by this		
		e Supervisor during the exit			practice.	,	
	conference.				p. dolloo.		
					2. A campus wide audit wa	S	
	3.1-19(b)				completed of all facility smoke		
					barriers to ensure compliance		
	2. Based on observa	ation and interview, the facility			state and federal regulatory		
	failed to ensure ope	nings through 1 of 1 ceiling			requirements		
	smoke barriers was protected to maintain the fire						
	resistance rating of	the smoke barrier. LSC			3. The Maintenance Direct	or	
		ection 8.5. Section 8.5.6.2 states			was educated on regulatory		
	1 ~	les, conduits, pipes and			requirements of smoke barrier	'S	
		ass through a floor/ceiling					
		ed as a smoke barrier, or			3. What measures will be p	out	
		membrane of a ceiling smoke			into place and what systemic		
	_	ected by a system or material			changes will be made to ensu		
		the transfer of smoke. Where			that the deficient practice does	s not	
		lso constructed as a fire barrier,			recur.		
	_	all be protected in accordance			4 The Maintanana		
	_	nts of Section 8.3.5 to limit the time period equal to the fire			The Maintenance Director/designed will inchest.	الم	
	_	sembly and Section 8.5.6. This			Director/designee will inspect smoke barriers throughout the		
		ould affect over 20 residents,			facility 5 times a week for 3	;	
	staff and visitors.	suid affect over 20 fesidents,			months to ensure regulatory		
	starr and visitors.				requirements are met related	to	
	Findings include:				smoke barriers	.0	
	<i>5</i>						
	Based on observation	ons with the Maintenance			4. How the corrective actio	n(s)	
		tour of the facility from 12:50			will be monitored to ensure the	` '	
		n 07/25/22, a one- and one-half			deficient practice will not recu	۲,	
	foot square hole wa	s noted in the ceiling of the			i.e., what quality assurance		
		by the kitchen which exposed			program will be put into place.		
	the attic above. Fiv	re pipes and conduits					
	_	ing. Two layers of 5/8ths inch			1. For quality assurance, the	ne	
		oted for the ceiling in the room.			Maintenance Director/designe	e	
	In addition, a one-fo	oot square hole was noted in			will review any findings yearly	, with	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE (SURVEY		
				COMPL			
		155665	B. WI	NG		07/26/	2022
	PROVIDER OR SUPPLIER			701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	T .	ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL]	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
K 0712 SS=F Bldg. 01	above two wall more room. Two layers of also noted for ceiling interview at the time. Maintenance Superwas replaced last we hole in the ceiling for aforementioned hole were not protected to rating of the ceiling. This finding was retained the Maintenance conference. 3.1-19(b) NFPA 101 Fire Drills Fire Drills Fire drills include to alarm signal and so conditions. Fire drills include to alarm signal and so conditions, at least The staff is familia aware that drills are routine. Where drills are undible alarms. 19.70 PM and 6:00 announcement maintenance with the drills are routine. Where drills are routine. Where drills are that drills are routine. Where drills are routine. Where drills are routines where drills are routines and fills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines. Where drills are routines where drills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines. The staff is familial aware that drills are routines.	the transmission of a fire simulation of emergency fire ills are held at expected mes under varying at quarterly on each shift. In with procedures and is re part of established ills are conducted between AM, a coded ay be used instead of	K 07	712	subsequent corrective action a education for identified staff. 2. Findings will be reported the QA meeting monthly or un substantial compliance has be determined. 5. Date of Compliance: 8-12-2022 The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusion so forth in the statement of deficiencies, or any violation.	at til en	08/12/2022

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155665	B. W	NG		07/26	/2022
				CTREET	ADDRESS SITV STATE ZIR COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD ENRY STREET		
MA IEST	IC CARE OF NORT	TH VEDNON			H VERNON, IN 47265		
IVIAJEST	IC CARE OF NOR	TH VERNON		NORT	- VERNON, IN 47205		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		eficient practice affects all			regulation. The provider		
	residents, staff and	visitors.			respectfully requests that St	tate	
					Report Plan of Corrections I	Эе	
	Findings include:				considerered the Letter of		
					Credible Allegation & reques	st a	
	Based on review of "Fire Drill Report" and Direct Supply TELS "Logbook Documentation: Perform a Fire Drill" documentation with the Maintenance Supervisor during record review from 9:40 a.m. to				desk review regarding plan	of	
					correction. The provider		
					alleges compliance as of		
	Supervisor during r	ecord review from 9:40 a.m. to			8/12/22		
	12:50 p.m. on 07/2:	5/22, documentation of a first					
	shift fire drill or sta	ff training documentation on					
	fire drill procedures	s on the first, second and third			1. What corrective action(s) will	
	shift in the fourth q	uarter (October, November,			be accomplished for those	,	
	December) 2021 wa	as not available for review. In			residents found to have been		
	addition, document	ation of a second shift and			affected by the deficient pract	ice.	
	third shift fire drill	or staff training documentation			1. All facility residents have		
	on fire drill procedu	ares on the second and third			potential to be affected by the		
	shift in the third qua	arter (July, August, September)			alleged deficient practice. Mo		
	2021 was also not a	vailable for review. Based on			forward from our Plan of Corr	-	
	interview at the tim	e of record review, the			date the facility will be conduc	cting	
	Maintenance Super	visor stated the facility			fire drills per shift quarterly pe	-	
		s per day and agreed			regulation.2. How other		
	_	fire drill or staff training on fire			residents having the potential	to	
	drill procedures for	the aforementioned shifts and			be affected by the same defic		
	quarters in 2021 wa	as not available for review.			practice will be identified and		
	_				corrective action(s) will be		
	This finding was re	viewed with the Administrator			taken.1. All Residents have	e the	
	and the Maintenanc	ee Supervisor during the exit			potential to be affected by this		
	conference.	-			practice.2. Moving forward		
					our Plan of Correction date th		
	3.1-19(b)				facility will be conducting fire		
	. '				per shift quarterly per		
	2. Based on record	review and interview, the			regulation.3. The Maintena	nce	
		cument the staff who			Director was educated on the		
		terly fire drills or staff training			regulation of having a fire drill		
		ire drill procedures on the			shift per calendar quarter.3.	1: =:	
		f 4 quarters and on the third			What measures will be put int	io.	
		ters. LSC Section 19.7.1.6			place and what systemic char		
	1		1		T P. 200 and milat by otonino onai	.900	I

requires drills to be conducted quarterly on each

shift under varied conditions. LSC Section

will be made to ensure that the

deficient practice does not

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155665	B. WI	NG		07/26	/2022
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8		1	NRY STREET		
MAJEST	IC CARE OF NORT	TH VERNON		1			
IVIAJEST	IC CARE OF NORT	H VERNON		NORTE	I VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		loyees of health care			recur.1. The Maintenance		
	_	e instructed in life safety			Director/designee will complet	e an	
	procedures and dev	ices. This deficient practice			audit quarterly to ensure that t	he	
	affects all residents.	, staff and visitors.			facility has fire drills conducted	d per	
					regulation.4. How the corre	ctive	
	Findings include:				action(s) will be monitored to		
					ensure the deficient practice w	vill	
	Based on review of "Fire Drill Report" and Direct				not recur, i.e., what quality		
	Supply TELS "Logbook Documentation: Perform a				assurance program will be put		
		ntation with the Maintenance			place.1. For quality assuran	ice,	
		ecord review from 9:40 a.m. to			the Maintenance		
	_	5/22, documentation of the staff			Director/designee will review a	-	
	who participated in the fire drill or staff training				findings daily, with subsequen		
		ire drill procedures on the			corrective action and educatio		
		irst quarter (January,			identified staff.2. Findings w		
		022 and the second quarter			be reported at the QA meeting]	
		2022 was not available for			monthly or until substantial		
		ation for the second shift fire			compliance has been		
		03/08/22 at 8:00 p.m. and on			determined.5. Date of		
	_	n. each did not include			Compliance: 8-12-2022		
		ne staff who participated in the					
	_	cedures. In addition,					
		ne staff who participated in the					
		ining documentation on fire drill					
	1 ^	nird shift for the second					
	_	so not available for review.					
		the third shift fire drill					
		/22 at 5:00 a.m. did not include					
		ne staff who participated in the					
	_	cedures. Based on interview at eview, the Maintenance					
		ne facility operates three shifts					
	1 -	documentation of staff who					
		ire drills or staff training on fire					
		the aforementioned shifts and					
		s not available for review.					
	quartors in 2022 wa	is not available for feview.					
	This finding was re	viewed with the Administrator					
	_	e Supervisor during the exit					
	conference.	- zapar ribor daring the eart					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/26/2022
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
K 0741	3.1-19(b) NFPA 101				
SS=D Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartn liquids, combustib used or stored and location, and such signs that read NC posted with the interest smoking. (2) In health care smoking is prohibit prominently place secondary signs was smoking shall not (3) Smoking by paresponsible shall lift (4) The requirement apply where the part supervision. (5) Ashtrays of not safe design shall lift where smoking is (6) Metal contained devices into which	ns shall be adopted and less than the following be prohibited in any room, ment where flammable le gases, or oxygen is do in any other hazardous area shall be posted with D SMOKING or shall be ternational symbol for no occupancies where ted and signs are do at all major entrances, with language that prohibits be required. Intents classified as not be prohibited. Into of 18.7.4(3) shall not attent is under direct and one provided in all areas permitted. It is not a shall be and a shall areas permitted. It is with self-closing cover a shall areas where			
	interview; the facili materials were depo containers with self	riew, observation and ty failed to ensure smoking sited into ashtrays and metal closing cover devices into be emptied of noncombustible	K 0741	The creation and submission this Plan of Correction does constitute an admission by provider of any conclusion forth in the statement of	s not this

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		A. BUILDING <u>01</u> COMPLETE		(X3) DATE SURVEY COMPLETED 07/26/2022		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	
MAJESTI	IC CARE OF NORT	TH VERNON			NRY STREET I VERNON, IN 47265	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG			
TAG		LISC IDENTIFYING INFORMATION esign in 1 of 2 outdoor areas		TAG		DATE
		taking place. This deficient			deficiencies, or any violation regulation. The provider	1 01
	_	t over 2 staff and visitors in			respectfully requests that St	tato
	-	utdoor staff smoking area at			Report Plan of Corrections b	
	-	r to the outside of the facility.			considerered the Letter of	
		•			Credible Allegation & reques	st a
	Findings include:				desk review regarding plan	
					correction. The provider	
	Based on review of				alleges compliance as of	
		the Maintenance Supervisor			8/12/22	
		w from 9:40 a.m. to 12:50 p.m.				
	·	ed residents and staff are				
	allowed to smoke in designated outdoor smoking areas. Based on observations with the Maintenance Supervisor during a tour of the facility from 12:50 p.m. to 3:30 p.m. on 07/25/22,					·
					1. What corrective action(s) will
					be accomplished for those	
		-			residents found to have been	
	_	tte butts were deposited into an ee can outside the facility at			affected by the deficient pract	ice.
		r to the outside of the facility			All residents have the	
		de of the building. Ashtrays			potential to be affected by the	
		s with self-closing cover			alleged deficient practice. All	
		ashtrays can be emptied of			cigarette butts were appropria	
		terial and safe design were not			disposed of in a metal or	atory
		door location where staff			non-combustible container wi	th a
	_	g place. Based on interview at			self-closing cover device.	
		rvations, the Maintenance				
	Supervisor stated th	e coffee can with the			2. How other residents have	ving
		tte butts has been there for			the potential to be affected by	the
		reed cigarette butts were not			same deficient practice will be	
	_	shtrays and metal containers			identified and what corrective	
	_	ver devices at this outdoor			action(s) will be taken.	
	location where staff	smoking was taking place.				
	Tl.:- £: 1'	and a second and advantage of the second advantage of the second and advantage of the second advantage of the second and advantage of the second advantage of the second and advantage of the second advantage of the second advantage of the second and advantage of the second advan			1. All Residents have the	
		viewed with the Administrator			potential to be affected by the	
	and the Maintenanc conference.	e Supervisor during the exit			alleged deficient practice. All	
	conterence.				cigarette butts were appropria	aleiy
	3.1-19(b)				disposed of in a metal or non-combustible container wi	th a
	J.1-17(0)				self-closing cover device.	ша
					Self-closing cover device.	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPLETED	
		155665	B. W	ING		07/26/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t			NRY STREET		
MAJEST	IC CARE OF NORT	TH VERNON			I VERNON, IN 47265		
	T		_		· · · · · · · · · · · · · · · · · · ·	ı	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	KEGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG		tho	DATE
					A campus wide audit of facility grounds was completed		
					eliminate all cigarette butts we		
					properly disposed of.	,,,,	
					proporty dioposed of.		
					3. The Maintenance Direct	or	
					was educated on the need to	I	
					all cigarette butts appropriatel	I	
					disposed of in a metal or		
					non-combustible container wit	h a	
					self-closing cover device.		
					0 14/1-14 27.1		
					3. What measures will be p	out	
					into place and what systemic	ro	
					changes will be made to ensu that the deficient practice does		
					recur.	3 1101	
			1		10001.		
					1. The Maintenance		
					Director/designee will complet	te an	
			1		audit 5 times a week for 3 mo		
					to ensure all cigarette butts we	ere	
			1		properly disposed of.		
					4. How the corrective actio	` '	
					will be monitored to ensure the	-	
					deficient practice will not recui	r,	
			1		i.e., what quality assurance program will be put into place.		
					program will be put into place.		
					1. For quality assurance, th	ne	
					Maintenance Director/designe		
					will review any findings daily,		
					subsequent corrective action a		
					education for identified staff.		
			1		2. Findings will be reported		
			1		the QA meeting monthly or un		
					substantial compliance has be	een	
					determined.		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	construction 01	(X3) DATE SURVEY COMPLETED	
		155665	B. WING		07/26/2022
	PROVIDER OR SUPPLIER		701 HI	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0916 SS=F Bldg. 01	Electrical Systems System Alarm Ann A remote annuncia powered is provide generating room in observed by opera annunciator is har conditions of the e- centralized compu- information system for the alarm annu- 6.4.1.1.17, 6.4.1.1 Based on observation failed to ensure 1 of annunciator panels condition. This def residents, staff and Findings include: Based on observation Supervisor during a p.m. to 3:30 p.m. or status indicator ligh annunciator panel le station was illumina Based on interview observations, the M he was not aware of stated the emergence building were to los	ator that is storage battery ed to operate outside of the n a location readily ating personnel. The d-wired to indicate alarm emergency power source. A atter system (e.g., building n) is not to be substituted anciator. 17.5 (NFPA 99) on and interview, the facility for 1 emergency generator was in proper operating ficient practice could affect all visitors. ons with the Maintenance tour of the facility from 12:50 n 07/25/22, the "not in auto" t for the wall mounted remote located at the C Hall nurse's sted indicating system trouble.	K 0916	The creation and submission this Plan of Correction does constitute an admission by a provider of any conclusions forth in the statement of deficiencies, or any violation regulation. The provider respectfully requests that St Report Plan of Corrections a considerered the Letter of Credible Allegation & request desk review regarding plan correction. The provider alleges compliance as of 8/12/22 1. What corrective action(s be accomplished for those residents found to have been	not shis set a of

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	(X2) MULTIPLE C A. BUILDING B. WING				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION panel was illuminated.	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY) affected by the deficient pract	DATE		
	This finding was re	viewed with the Administrator e Supervisor during the exit		1. All residents have the potential to be affected by the alleged deficient practice. The facility corrected the concernathe "not in auto" status indicallight for the wall mounted remannunciator panel located at hall nurse's station, the light is longer illuminated. 2. How other residents have the potential to be affected by same deficient practice will be identified and what corrective action(s) will be taken. 1. All Residents have the potential to be affected by this practice. 2. Education was provided the Maintenance Director of the regulation of regarding remote annunciator related to generate functionality and operations 3. What measures will be into place and what systemic changes will be made to ensure that the deficient practice does recur? 1. The Maintenance Director of the complete audits times a week for 3 months ducampus rounding to ensure annunciator is properly functional in compliance with state and in compliance with state.	e with cor oote the C is no ving the e e e e e e e e e e e e e e e e e e		

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Facility ID: 010996

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 01 COMPLE B. WING 07/26/2			ETED		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION	TAG	federal regulations 4. How the corrective actio will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. 1. For quality assurance, the Maintenance Director/designe will review any findings daily, we subsequent corrective action and education for identified staff. 2. Findings will be reported the QA meeting monthly or unsubstantial compliance has be determined. 5. Date of Compliance: 8-12-2022	e r, ne ee with and	DATE	
K 0918 SS=F Bldg. 01	System Maintenar The generator or source and associ of supplying service 10-second criterio monthly test, a pre annually confirm to safety and critical and testing of the switches are perfor	s - Essential Electric Syste s - Essential Electric nce and Testing other alternate power lated equipment is capable be within 10 seconds. If the n is not met during the locess shall be provided to his capability for the life branches. Maintenance generator and transfer locetic med in accordance with					

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exercised under load 30 minutes 12 times a

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155665	B. W	ING		07/26/	2022
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORTH VERNON		<u> </u>	701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I E	DATE
	once every 36 mo Scheduled test un a complete simula automatic or manuloads, and are corpersonnel. Mainte energy power sou accordance with Noticuit breakers are program for period components is est manufacturer requipal of maintenance are and readily availal and circuits are mand separate from Minimizing the postemergency power consideration for refeated to do monthly load testing recent 12-month period of NFPA 110, 2010 Emergency and State 8.4.2. Section 8.4.2 service shall be exert for a minimum of 3 following methods: (1) Loading that mangas temperatures as manufacturer (2) Under operating not less than 30 per Power Supply) name Section 8.4.2.3 states	ual transfer of all EES inducted by competent inance and testing of stored irces (Type 3 EES) are in NFPA 111. Main and feeder re inspected annually, and a dically exercising the tablished according to uirements. Written records and testing are maintained ble. EES electrical panels arked, readily identifiable, an normal power circuits. essibility of damage of the resource is a design new installations. (NFPA 99), NFPA 110, 0 (NFPA 70) review and interview, the recument emergency generator g for 6 months of the most riod to meet the requirements to Edition, the Standard for andby Powers Systems, Chapter to states diesel generator sets in recised at least once monthly, to minutes, using one of the the standard by the the temperature conditions and at	K 0	918	The creation and submission this Plan of Correction does constitute an admission by the provider of any conclusion is forth in the statement of deficiencies, or any violation regulation. The provider respectfully requests that Star Report Plan of Corrections be considerered the Letter of Credible Allegation & request desk review regarding plan of correction. The provider alleges compliance as of 8/12/221. 1. What corrective action(s) be accomplished for those residents found to have been	not his et of ate e	08/12/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155665 B. WING 07/26/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 HENRY STREET MAJESTIC CARE OF NORTH VERNON NORTH VERNON, IN 47265 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 8.4.2 shall be exercised monthly with the available affected by the deficient practice. EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental 1. All residents have the loads at not less than 50 percent of the EPS potential to be affected by the nameplate kW rating for 30 continuous minutes alleged deficient practice. Facility and at not less than 75 percent of the EPS generator has been tested "under nameplate kW rating for 1 continuous hour for a load" and" with no load". Facility total test duration of not less than 1.5 continuous generator met requirements during hours. This deficient practice could affect all testing residents, staff and visitors. 2. How other residents having Findings include: the potential to be affected by the same deficient practice will be Based on review of Direct Supply TELS Logbook identified and what corrective Documentation "Emergency Power Generators: action(s) will be taken. Test Generator Under Load" documentation for the most recent twelve-month period with the 1. All Residents have the Maintenance Supervisor during record review potential to be affected by this from 9:40 a.m. to 12:50 p.m. on 07/25/22, monthly practice. load testing documentation for the facility's diesel fired emergency generator for the six-month The Maintenance Director period of August 2021 through January 2022 was was educated on the regulation of not available for review. Based on interview at the all facility generator testing and time of record review, the Maintenance Supervisor documenting in TELs stated he started working at the facility earlier in 2022 and agreed monthly load testing What measures will be put documentation for the aforementioned six-month into place and what systemic period was not available for review. changes will be made to ensure that the deficient practice does not This finding was reviewed with the Administrator recur. and the Maintenance Supervisor during the exit conference. The Maintenance Director/designee will audit weekly 3.1-19(b) that all documentation and testing of the facility generator is 2. Based on record review and interview, the completed in accordance with facility failed to ensure a written record of weekly state and federal regulations inspections for the emergency generator set was maintained for 31 weeks of the most recent How the corrective action(s)

52-week period. This deficient practice could

will be monitored to ensure the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/26/2022			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION		
TAG	REGULATORY OR affect all residents,	LSC IDENTIFYING INFORMATION staff and visitors.	TAG	deficient practice will not recu	DATE		
	Findings include:			i.e., what quality assurance program will be put into place			
	Documentation "En Generator (with no Maintenance Superfrom 9:40 a.m. to 12 inspection document fired emergency ger of 08/21/21 through review. Based on it review, the Mainten started working at the agreed weekly gene documentation for the period was not avail.	he aforementioned 31-week		 For quality assurance, the Maintenance Director/designed will review any findings yearly subsequent corrective action education for identified staff. Findings will be reported the QA meeting monthly or unsubstantial compliance has bed determined. Date of Compliance: 8-12-2022 	ee r, with and at at		
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipme Extens Electrical Equipme Extension Cords Power strips in a pused for compone patient-care-relate (PCREE) assemble assembled by qua the conditions of 1 the patient care vi non-PCREE (e.g., except in long-terr	ent - Power Cords and ent - Power Cords and ent - Power Cords and eatient care vicinity are only ints of movable de electrical equipment des that have been diffied personnel and meet 0.2.3.6. Power strips in cinity may not be used for personal electronics), in care resident rooms that E. Power strips for PCREE					

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	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155665		UILDING	01	COMPL 07/26/	ETED
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORTH VERNON			701 HE	ADDRESS, CITY, STATE, ZIP COD NRY STREET I VERNON, IN 47265			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	for non-PCREE in (outside of vicinity non-patient care rother UL standard used with general cords are not used wiring of a structu temporarily are recompletion of the installed and mee 10.2.3.6 (NFPA 99 (NFPA 70), 590.3 Based on record revinterview; the facilitiex tension cords incused as a substitute requires utilities to 9.1.2 requires electromply with NFPA 2011 Edition. NFP unless specifically pables shall not be wiring of a structure building service equivalent for life safety shall approved in accordatandards. NFPA 9 Facilities, 2012 editional patients are intended Patient care vicinity location intended for treatment of patient beyond the normal table, treadmill, or apatient during exampatient care vicinity (2.3 m) above the first care intended for the patient during exampatient care vicinity (2.3 m) above the first care intended for the patient during exampatient care vicinity (2.3 m) above the first care vicinity (2.3 m) a	the patient care rooms the power strips meet the common the precautions. Extension the as a substitute for fixed the care in the conditions of the care facility wherein the care the care the care the care facility wherein the care the care the care the care facility the care the ca	K 0	920	The creation and submission this Plan of Correction does constitute an admission by t provider of any conclusion s forth in the statement of deficiencies, or any violation regulation. The provider respectfully requests that St. Report Plan of Corrections b considerered the Letter of Credible Allegation & request desk review regarding plan correction. The provider alleges compliance as of 8/12/22 1. What corrective action(s) be accomplished for those residents found to have been affected by the deficient praction. The rooms/offices found be of concern during the survey.	not his et of ate e t a of	08/12/2022

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665			(X3) DATE SURVEY COMPLETED 07/26/2022		
NAME OF	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD		
	IC CARE OF NOR				NRY STREET I VERNON, IN 47265		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		T-	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
		d with grounding conductors			has had the power strips remo	ved.	
	*	s shall be permitted provided					
		l within the patient care			2. How other residents hav	-	
	20 residents, staff a	eient practice could affect over			the potential to be affected by		
	20 residents, starr a	ind visitors.			same deficient practice will be identified and what corrective		
	Findings include:				action(s) will be taken.		
	i manigs merade.				detion(s) will be taken.		
	Based on review of	"Electrical Safety for			All residents, staff, and		
	Residents" policy of	locumentation dated 12/17/20			visitors have the potential to b	е	
		ce Supervisor during record			affected by this practice		
	review from 9:40 a.m. to 12:50 p.m. on 07/25/22, the						
		hall not be used as a substitute			A campus wide audit wa		
	for adequate wiring in the facility". In addition,				completed to ensure that only		
		ower strips shall not be used			approved power strips are bei	-	
		dequate electrical outlets in strips may be used for a			used and no multi-plug adapte	ers in	
		and printer". The policy also			the laundry areas.		
	_	os shall not be used with			3. The Maintenance Direct	or	
	_	resident-care areas". in lieu of			was educated on the regulation of		
		s prohibited". Based on			only approved power strips to be		
		he Maintenance Supervisor			used in the facility and no		
	during a tour of the	facility from 12:50 p.m. to 3:30			multi-plug adapters in the laur	ıdry	
		cell phone charging cable was			areas.		
		er strip placed on the floor					
		he resident bed nearest the			3. What measures will be p	out	
		sident Room C110. The UL			into place and what systemic		
		strip could not be determined.			changes will be made to ensu		
		ing cable was plugged into a on the floor of the C Hall			that the deficient practice does	s not	
		on the floor of the C Hair operating fan was plugged into			160al f		
		n the water softener room near			1. The Maintenance		
		on interview at the time of the			Director/designee will conduct		
		faintenance Supervisor stated			audits 5 times a week for 3		
		e fan in the water softener room			months during facility rounding	g to	
		k as the room was excessively			ensure only approved power		
		wer strip was being used in			stripes are in use throughout t	he	
		inity in Room C110 and			facility		
		re being used as a substitute					
	for fixed wiring at	the aforementioned locations.			4. How the corrective actio	n(s)	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155665	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 07/26/2022
	PROVIDER OR SUPPLIER		701 HE	ADDRESS, CITY, STATE, ZIP COD ENRY STREET H VERNON, IN 47265	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE COMPLETION DATE
	_	viewed with the Administrator e Supervisor during the exit		will be monitored to ensure deficient practice will not re i.e., what quality assurance program will be put into plate. The program will be reported by the program will be put into plate. The program will be pu	ecur, e ace. e, the gnee illy, with on and ff. rted at r until s been
K 0923 SS=E Bldg. 01	Storag Gas Equipment - Storage Greater than or ed Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 d Storage locations enclosure or within space of non- or li construction, with that can be secure stored with flamm from combustibles sprinklered) or enc	Cylinder and Container Cylinder and Container qual to 3,000 cubic feet are designed, constructed, accordance with 5.1.3.3.2 cubic feet are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) ed. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155665 NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORTH VERNON SUMMARY STATEMENT OF DEFICIENCIE (CACID DEFICIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OR LSC (IDENTEYING INTORMATION Minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: CXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.5.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 storage locations of nonflammable gases equal to or greater than 3000 cubic feet were secured against unauthorized entry. NFPA 99 (Easth Care Facility Edition Color, 2012)	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER MAJESTIC CARE OF NORTH VERNON SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure I of 1 storage locations of nonflammable gases equal to or greater than 3000 cubic feet were secured against unauthorized STREET ADDRESS, CITY, STATE, ZIP COD ACM HENRY STREET NORTH VERNON, IN 47265 PREFIX TAG #ACH DEFICIENCY #ACH DEFICIENCY PREFIX TAG #ACH DEFICIENCY #ACH DEFICIENCY PREFIX TAG #ACH DEFICIENCY #ACH DEFICIENCY #ACH DEFICIENCY #ACH DEFICIENCY #ACH DEFICIENCY #ACH DEFICIENCY #ACH DEFICIENCY #ACH	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED	
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MAJESTIC CARE OF NORTH VERNON (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 storage locations of nonflammable gases equal to or greater than 3000 cubic feet were secured against unauthorized 701 HENRY STREET NORTH VERNON; IDA NORTH					STREET A	ADDRESS CITY STATE ZIP COD			
MAJESTIC CARE OF NORTH VERNON (X4) ID PRIFIX (A24) ID PRIFIX TAG SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 storage locations of nonflammable gases equal to or greater than 3000 cubic feet were secured against unauthorized NORTH VERNON, IN 47265 ID PROVIDERS PLANON CORDENTIVE ACTIONS SOBLED IN COMPILATION TAG PROVIDERS PLANON CORDENTIVE ACTIONS SOBLED IN COMPILATION TAG IN PROVIDERS PLANON CORDENTIVE ACTIONS SOBLED IN COMPILATION DATE TAG IN PROVIDERS PLANON CORDENTIVE ACTIONS SOBLED IN COMPILATION DATE TAG IN PROVIDERS PLANON CORDENTIVE ACTIONS SOBLED IN COMPILATION DATE TAG IN PROVIDERS PLANON CORDENTIVE ACTIONS SOBLED IN COMPILATION DATE IT AG IN PROVIDERS PLANON CORDENTIVE ACTIONS SOBLED IN COMPILATION DATE TAG IN PROVIDERS PLANON CORDENTIVE TAG PREFIX TAG PROVIDERS PLANON CORDENTIVE DATE TAG IN PROVIDERS PLANON CORDENTIVE TAG PREFIX TAG PROVIDERS PLANON CORDENTIVE DATE TAG IN	NAME OF P	PROVIDER OR SUPPLIEF	₹						
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG REGULATORY OR LSC IDENTIFYING INFORMATION Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 storage locations of nonflammable gasse equal to or greater than 3000 cubic feet were secured against unauthorized ID PREFIX TAG PREFIX TAG	ΜΔ ΙΕςΤ	IC CARE OF NORT	TH VERNON						
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		1 -				forth in the statement of	- •		
Edition, Section 11.3.2.1 states storage locations deficiencies, or any violation of			_			_	OT		
shall be outdoors in an enclosure or within an regulation. The provider							-4-		
enclosed interior space of noncombustible or respectfully requests that State		_							
limited combustible construction, with doors (or Report Plan of Corrections be						-	е		
gates outdoors) that can be secured against considerered the Letter of considerered the Letter of Credible Allocation 8 request a		~	C				4		
unauthorized entry. This deficient practice could Credible Allegation & request a			-			_			
affect 10 residents, staff and visitors in the desk review regarding plan of		· ·) i		
vicinity of the oxygen storage and transfilling correction. The provider						-			
room by the kitchen. alleges compliance as of 8/12/22		100m by the kitcher	1.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PW8K21 Facility ID: 010996

If continuation sheet Page 48 of 50

PRINTED: 08/17/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155665	A. BUILDING B. WING				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 701 HENRY STREET NORTH VERNON, IN 47265				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Based on observation Supervisor during a p.m. to 3:30 p.m. or door to the oxygen and the kitchen was on the door to secur unauthorized entry. Was not functioning door. In addition, the corridor door failed frame when tested the room contained four seventeen 'E' type of interview at the time Maintenance Supervited door to the oxygen was not locked to seentry and failed to least the supervision of the oxygen and failed to least the supervision of the oxygen and failed to least the supervision of the oxygen and failed to least the supervision of the oxygen and failed to least the supervision of the oxygen and failed to least the supervision of the oxygen and failed to least the supervision of the oxygen and failed to least the supervision of the oxygen and failed to least the supervision of the oxygen and failed to least the supervision of the oxygen and failed to least the oxygen and failed to least the oxygen and the oxygen	ons with the Maintenance tour of the facility from 12:50 a 07/25/22, the corridor entry storage and transfilling room is equipped with a keypad lock the the door against However, the keypad lock properly and did not lock the ne latching mechanism for the to latch the door into the door to close multiple times. The r liquid oxygen containers and axygen cylinders. Based on the observations, the visor agreed the corridor entry storage and transfilling room the cure against unauthorized atch into the door frame. The viewed with the Administrator the Supervisor during the exit		What corrective action(s) will accomplished for those reside found to have been affected by deficient practice. 1. All residents have the potential to be affected by the alleged deficient practice2. keypad was repaired to be in working condition and the loci mechanism on the door was repaired to, so it latches in accordance with state and feer regulations 2. How other residents having the potential be affected by the same deficipractice will be identified and corrective action(s) will be taken.1. All Residents have potential to be affected by this practice.2. Education was provided to the Maintenance Director of the regulation of his nonflammable gases equal to greater than 3000 cubic squal feet secured against unauthous entry. 3. What measures we put into place and what system changes will be made to ensuthat the deficient practice does recur.1. The Maintenance Director/designee will identified areas are protector against unauthorized entry by conduct audits 5 times a week for 3 months during facility rounding4. How the correct action(s) will be monitored to ensure the deficient practice we have the deficient practice to the source of the deficient practice of the source of the deficient practice of the source of t	The king leral to ient what ethe saving or recized ill be mic res s not ed ting live		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/17/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED <u>01</u> 155665 B. WING 07/26/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 701 HENRY STREET MAJESTIC CARE OF NORTH VERNON NORTH VERNON, IN 47265 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE not recur, i.e., what quality assurance program will be put into place.1. For quality assurance, the Maintenance Director/designee will review any findings daily, with subsequent corrective action and education for identified staff.2. Findings will be reported at the QA meeting monthly or until substantial

compliance has been determined.5. Date of Compliance: 8-12-2022

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: PW8K21 Facility ID: 010996 If continuation sheet Page 50 of 50